DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/05/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G002	A. BUILDING _____ B. WING _____	C 01/15/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N C C	6200 2ND STREET, NW WASHINGTON, DC 20011

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W 000	INITIAL COMMENTS On January 10, 2008, the State Agency received notification via telephone that Client #1 had been taken to the emergency room for vomiting and abdominal pain. Subsequently, he died that morning (January 10, 2008) at approximately 8:55 AM in the emergency room. Due to the nature of this incident, an on-site investigation was initiated on January 10, 2008. Although there was no evidence that the facility was negligent in the death of this client, incidental findings revealed the facility was out of compliance with standard level requirements. The deficiencies identified in this report were based on the review of program and training records, Incident reports, the Medication Administration record and Health Passport, Personnel Records, Policy and Procedures and staff interviews. The Medical/Clinical record was not available at the time of the investigation. Interview with the Program Manager revealed that the record was missing and could not be located.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on staff interview and record review conducted during the incident investigation, the facility's governing body failed to maintain general operating direction over the facility as evidenced by the deficiencies cited throughout this report. The findings include:	W104	1. The agency will review its current practices and policy regarding the storage and access to "client" medical and clinical records by March 1, 2008. The appropriate revisions will be made or a new policy will be developed to address the concern by March 15, 2008. Currently, there is only one key to the nursing office that is available to the direct care supervisor on duty. Access to medical records was only given to individuals who needed to access the "client's" records as part of their job function.	3-1-08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cordero Harper — TITLE: Program Manager — (X6) DATE: 2/15/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 The governing body failed to ensure sufficient safeguards were in place to protect clients ' confidential records. 1. On 1/10/08 at approximately 4:30 PM, the Program Manager reported that Client #1 ' s Medical/Clinical record was missing from the main nursing station. Interview with the Director of Nursing revealed that not only do the nurses have access to this area, numerous non-medical personnel (Direct Care Supervisors, onsite professionals, administration) have key access to this area. The Governing Body failed to have a policy or written an effective system to ensure clients' medical recores were safeguarded and kept confidential. As of 1/15/08, Client #1 ' s record remained unavailable. 2. [Cross refer to W192] The governing body failed to ensure that all staff had been effectively trained on signs and symptoms of illness, as well as , reporting requirements.	W 104	1. The agency will review its current practices and policy regarding the storage and access to "client" medical and clinical records by March 1, 2008. The appropriate revisions will be made or a new policy will be developed to address the concern by March 15, 2008. Currently, there is only one key to the nursing office that is available to the direct care supervisor on duty. Access to medical records was only given to individuals who needed to access the "client's" records as part of their job function.	3-1-08
W 112	483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to keep confidential, all information contained in each client's record, for one sampled client. (Client #1) The finding includes: On 1/10/08 at approximately 4:30 PM, the Program Manager reported that Client #1's	W 112	2. See response to W192.	

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W 112	Continued From page 2 Medical/Clinical record was missing from the main nursing station. Interview with the Director of Nursing revealed that not only do the nurses have access to this area, numerous non-medical personnel (Direct Care Supervisors, onsite professionals, administration) have key access to this area. The Governing Body failed to have a policy or written an effective system to ensure clients' medical records were safeguarded and kept confidential. As of 1/15/08, Client #1 ' s record remained unavailable.	W112	The agency will continue to limit access to the medical records. A new record cabinet has been identified and will be ordered by February 15, 2008 to replace the portable record racks. Anyone needing access to a record will gain access from the nurse on duty or the nurse manager.	2- 15-08
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables them to perform his or her duties effectively, efficiently and competently. The finding includes: The facility failed to ensure that all staff had been effectively trained on signs and symptoms of illness, as well as , reporting requirements as evidenced below: During staff interview with the facility's Compliance Specialist and review of the facility's training records on 1/14/08, it was determined that none of the facility staff had received training on detecting the "Signs and symptoms of illness". This was verified by the facility Director of Nursing (DON)on 1/15/08. According to the DON, a	W 192		
		W192	The program staff will receive training on the Sign and Symptoms of Illness. Training began on February 13, 2008. The first cycle will be completed by March 15, 2008. The program staff will receive this training at least annually. The program will maintain a record of the participants. Beginning March 1, 2008, the program will add training on The Signs and Symptoms of Illness to the orientation process.	2-13-08 through 3-15-08 3-1-08

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W 192	Continued From page 3 nurse was in the facility, seven days a week to provide nursing care. Although there was a nurse onsite 24 hours a day, it was discovered, during the investigation process, that direct support staff had failed to communicate one health related incident on 1/10/08 involving Client #1. Interview conducted with the overnight direct care staff on 1/11/08 at 11:00 AM revealed that during her shift around 12 AM on 1/10/08 she noticed that Client #1's urine color was dark brown. Staff also reported that Client #1 had experienced earlier eposides of vomiting of food and fluids and had not consumed a great deal of replacement fluids. A review of the nurses communication log book (change of shift record for nurses) contained entries for 1/9/08 and 1/10/08. On 1/9/08, the log reflected mention of constipation and vomiting, and vitals were documented. On 1/10/08 there was documentation about his vomiting, vital and bowel signs and the order to transport to the emergency room. Both entries were brief descriptions of the nights events, that included other client information as well. Interview with the two nurses that were on duty 1/10/08, did not result in any indication that he had been informed of Client #1's dark color urine. Athough the nurse stated that detailed entries were documented in Client #1's Medical Record, this could not be confirmed due to the unavailability of the record.	W 192		

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I 000	INITIAL COMMENTS On January 10, 2008, the State Agency received notification via telephone that Resident #1 had been taken to the emergency room for vomiting and abdominal pain. Subsequently, he died that morning (January 10, 2008) at approximately 8:55 AM in the emergency room. Due to the nature of this incident, an on-site investigation was initiated on January 10, 2008. Although there was no evidence that the GHMRP was negligent in the death of this resident, incidental findings revealed the facility was out of compliance with standard level requirements. The deficiencies identified in this report were based on the review of program and training records, Incident reports, the Medication Administration record and Health Passport, Personnel Records, Policy and Procedures and staff interviews. The Medical/Clinical record was not available at the time of the investigation. Interview with the Program Manager revealed that the record was missing and could not be located.	I 000		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee had been provided with adequate training that enables them to perform his or her duties effectively, efficiently and competently. The finding includes: The GHMRP failed to ensure that all staff had been effectively trained on signs and symptoms	I 222	The program staff will receive training on the Sign and Symptoms of Illness. Training began on February 13, 2008. The first cycle will be completed by March 15, 2008. The program staff will receive this training at least annually. The program will maintain a record of the participants. Beginning March 1, 2008, the program will add training on The Signs and Symptoms of Illness to the orientation process.	2-13-08 through 3-15-08

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I 222	Continued From page 1 of illness, as well as , reporting requirements as evidenced below: During staff interview with the facility's Compliance Specialist and review of the facility's training records on 1/14/08, it was determined that none of the GHMRP staff had received training on detecting the "Signs and symptoms of illness". This was verified by the facility Director of Nursing (DON)on 1/15/08. According to the DON, a nurse was in the GHMRP, seven days a week to provide nursing care. Although there was a nurse onsite 24 hours a day, it was discovered, during the investigation process, that direct support staff had failed to communicate one health related incident on 1/10/08 involving Resident #1. Interview conducted with the overnight direct care staff on 1/11/08 at 11:00 AM revealed that during her shift around 12 AM on 1/10/08 she noticed that Resident #1's urine color was dark brown. Staff also reported that Resident #1 had experienced earlier eposides of vomiting of food and fluids and had not consumed a great deal of replacement fluids. A review of the nurses communication log book (change of shift record for nurses) contained entries for 1/9/08 and 1/10/08. On 1/9/08, the log reflected mention of constipation and vomiting, and vitals were documented. On 1/10/08 there was documentation about his vomiting, vital and bowel signs and the order to transport to the emergency room. Both entries were brief descriptions of the nights events, that included other client information as well. Further Interview with the nurse that was on duty	I 222		

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I 222	Continued From page 2 1/10/08, did not result in any indication that he had been informed of Resident #1's dark color urine. Athough the nurse stated that detailed entries were documented in Client #1's Medical Record, this could not be confirmed due to the unavailability of the record.	I 222		
I 290	3514.1 RESIDENT RECORDS Each GHMRP or licensee shall retain a permanent record for each resident for at least five years (5 yrs.) after the resident ' s discharge or death. This Statute is not met as evidenced by: Based on staff interview and record review conducted during the incident investigation, the GHMRP failed to maintain general operating direction over the facility as evidenced by the deficiencies cited throughout this report. The findings include: The GHMRP failed to ensure sufficient safeguards were in place to protect clients ' confidential records. On 1/10/08 at approximately 4:30 PM, the Program Manager reported that Resident #1's Medical/Clinical record was missing from the main nursing station. Interview with the Director of Nursing revealed that not only do the nurses have access to this area, numerous non-medical personnel (Direct Care Supervisors, onsite professionals, administration) have key access to this area. The Governing Body failed to have a policy or written an effective system to ensure clients' medical records were safeguarded and kept confidential. As of 1/15/08, Resident #1 ' s record remained unavailable.	I 290	The agency will continue to limit access to the medical records. The agency ordered a locked record cabinet on February 15, 2008 to replace the portable record racks. Anyone needing access to a record will gain access from the nurse on duty or the nurse manager.	2-15 -08

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I 290	Continued From page 3	I 290		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to observe and protect the rights of a resident, in accordance with D.C. Law 2-137 (now Title 7, Chapter 13), and this chapter. The finding includes: The governing body failed to ensure sufficient safeguards were in place to protect clients ' confidential records. On 1/10/08 at approximately 4:30 PM, the Program Manager reported that Client #1 ' s Medical/Clinical record was missing from the main nursing station. Interview with the Director of Nursing revealed that not only do the nurses have access to this area, numerous non-medical personnel (Direct Care Supervisors, onsite professionals, administration) have key access to this area. The Governing Body failed to have a policy or written an effective system to ensure clients' medical recores were safeguarded and kept confidential. As of 1/15/08, Client #1 ' s	I 500	The agency will review its current practices and policy regarding the storage and access to "client" medical and clinical records by March 1, 2008. The appropriate revisions will be made or a new policy will be developed to address the concern by March 15, 2008. Currently, there is only one key to the nursing office that is available to the direct care supervisor on duty. Access to medical records was only given to individuals who needed to access the "client's" records as part of their job function.	3-1-08 3-15-08

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I 500	Continued From page 4 record remained unavailable.	I 500		